Welcome !

Please take a few minutes to answer the following questions
so we can better assist you with your health care needs.

Patient Information

Date _____ Social Security# _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer / School _____ Business Phone _____

Business Address _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact ? _____ Phone _____

Primary Dental Insurance

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if different from patient's) _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Claims Address _____ Insurance Phone _____

Subscriber I.D.# _____ Group# _____

Additional Dental Insurance

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec.# _____

Address (if different from patient's) _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Claims Address _____ Insurance Phone _____

Subscriber I.D.# _____ Group# _____

PLEASE COMPLETE REVERSE SIDE